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Special Article

A Family Practice Survey in Ventura County

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■ *Seventy-five percent of family practitioners in Ventura County, California, responded to a seven-page mailed questionnaire. One third of the practitioners do no obstetrics. The physicians counsel seven patients to every delivery performed and to every surgical procedure performed. Family practice consists of medicine and pediatrics, rather than surgery, obstetrics and psychiatry. Family practitioners use referrals to community health care services in a limited fashion. Lack of information about availability of community resources may be the reason.*

THIRTY-EIGHT YEARS AGO more than four out of every five physicians in private practice declared themselves to be general practitioners.[1] By 1968 this proportion had dropped to 15 percent, with increased specialization. Then in 1957, the realization that someone was needed to assume responsibility for the patient's continuing health needs led to a re-evaluation. A committee was appointed on Preparation for Family Practice.[2] This led to the establishment of new residency programs, and eventually to the formation of a new specialty board in Family Practice.

To better understand the role of the family practitioner, a survey was conducted in Ventura County.

Method

The questionnaire was either mailed or personally delivered. With the questionnaire a cover letter from the Director of Medical Education was enclosed expressing the purpose as well as inviting the recipient's considered cooperation. Initial non-respondents were contacted with a second questionnaire and cover letter. There was a total of 71 respondents out of 96 for a return rate of 75 percent, this proportion agreeing favorably with other surveys of this type.[3,4,5] For many of the questions these categories were used: Medical, Surgical, Pediatric, Obstetrics-Gynecological and Psychiatric.

Results

Forty-three percent of the respondents fell in the age group 36 to 45. The second largest group was 46 to 55. The respondents were all male family practitioners with a median age of 41. Approximately one half had completed a general or family practice residency. The average number of years in practice for the respondents was 13.5. The largest number of practitioners (26 percent) had been in practice for six to ten years. A large group (19 percent) have been in practice for over 25 years.

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Type of Patient Seen in the Office: (Medical, Surgical, Pediatric, Obstetrics-Gynecological, and Psychiatric)

It was clear from the survey that medical patients were the most numerous. A majority of practitioners see 11 or more medical patients in the office each day. Pediatric patients also make up a large category. A few obstetrics-gynecological and surgical patients are seen each day by a small number of physicians. Almost no physicians said they saw psychiatric patients in their offices.

Type of Patient Seen by the Family Practitioner in the Hospital: (Medical, Surgical, Pediatric, Obstetric-Gynecological and Psychiatric).

Again, medical patients were most frequently seen by the largest number of physicians. Almost all physicians see an average of one or more such patients each day. Surgical patients are the next most frequently seen. Most practitioners see at least one surgical patient each day in the hospital, and 20 said they see at least two per day. Only nine physicians said they see three or more pediatric or obstetric-gynecological patients a day. Practically no part of the family practitioner's hospital day is taken up with psychiatric work.

Type of Patient Seen with Chronic Condition in the Office: The chronically ill do not occupy most of the physician's work day. When he devotes time to chronic care treatment, it will most likely be the diseases of the aged with deterioration of heart, lungs and joints. While few practitioners see acute psychiatric conditions, a significant case load of chronic psychiatric cases is part of their practice.

Diagnostic Procedures Used by Family Practitioners: Most of the family practitioners surveyed used one or more formal diagnostic procedures. The diagnostic techniques most used correlate with the types of problems the practitioners see in the office and at the hospital. X-ray services are needed. The most common types of x-ray procedures are listed in Table 1. If a family practitioner makes use of office x-ray techniques, he is most likely to be concerned with extremities. Chest films are next most common. It is unlikely that a general practitioner will be involved in upper gastrointestinal series, lower gastrointestinal series, intravenous pyelogram, gallbladder series or other x-ray procedures.

TABLE 1.—*Number of Practitioners Using Six Office X-Ray Procedures*

Type of X-Ray Procedure	*Number of Physicians*
Long Bones and Joints	35
Chest	26
Small bones (hands, feet)	19
Skull	17
Flat plate of abdomen	16
Back	14

Other Diagnostic Procedures: Several diagnostic techniques in addition to x-ray procedures are commonly done by family practitioners. The three most commonly stated—urinalysis, electrocardiograms and sigmoidoscopy—are done by the majority of physicians responding. Complete blood cell count, urine Gram stain and tonometry are the next most common techniques mentioned, typically used by about one out of three general practitioners. Other procedures, such as spinal taps, sputum culture and pulmonary function tests are used infrequently.

Treatment Procedures Used by Family Practitioners: One of the major purposes of this survey was to determine the extent to which family practitioners are involved in various types of treatment procedures. The topics chosen for study were surgery, surgical assists, deliveries and counseling of patients.

Surgery Performed by the Family Practitioners:

While some family practitioners engage in little or no surgery they are a minority. About half of the survey sample performed a fairly wide range of procedures, although clearly the number of cases is small considering the schedule of surgery maintained by a specialist in this field. The most frequent surgical procedures performed by family practitioners are presented in Table 2. If a family practitioner is involved in surgery it most likely will be a biopsy, tonsillectomy and adenoidectomy, or fracture setting. About half of the practitioners perform these procedures, or the next most common, dilatation and curettage, hernia or appendectomy, at least once a month.

Surgery in Which the Family Practitioner Assists:

Many family practitioners typically assist surgeons. The physician either assists because it is his practice to do no surgery or because he does

TABLE 2.—*Number of Procedures per Physician per Month in Ten Main Categories*

Type of Procedure	*0*	*1*	*2*	*3 or more*
Biopsy	5	15	20	24
Tonsils and Adenoids	17	12	16	20
Fracture Setting	14	15	20	13
Dilatation and Curettage	10	34	15	4
Hernia	25	24	10	4
Appendectomy	23	30	7	1
Hysterectomy	36	19	6	1
Hemorrhoids	23	35	3	0
Cesarean section	34	23	1	1
Cholecystectomy	37	25	1	0

only the less complicated procedures on his own and calls in a specialist for cases in which his own experience is more limited. About once a month the practitioner is likely to assist in operations for hysterectomy, hernia, appendectomy or gallbladder. Family physicians are less involved in other types of major operations such as abdominal, chest or vascular procedures.

Deliveries Performed by the Family Practitioner: Almost one-third of the family practitioners surveyed report they do no deliveries at all. A smaller group do one or two deliveries a month. Some physicians devote considerable time to obstetrics; over half the survey respondents perform one delivery a week or more. Further study of data on physicians not performing deliveries and those actively engaged in obstetrics indicates that the practitioner who performs five deliveries or more is younger and more likely to have had a general practice residency.

Counseling Performed by the Family Practitioner: In addition to medical consultation, surgical procedures and deliveries, most family practitioners are called on to give some counseling on an amazing variety of topics. These may include, in a typical week, two or more psychosomatic conditions, marital problems, individual adjustment problems and sexual difficulties. These data agree with reports by other investigators.[6,7] Other conditions in which counsel is given are senility and discipline problems, although the practitioner tends to avoid getting involved in alcoholism and drug addiction problems.[8,9,10] The number of family practice physicians who do no counseling in addition to their strictly medical duties is small.

It is significant that in an average month, the family practitioner gives counsel for psychological problems to seven times as many patients as he delivers, and also seven times as many as his number of surgical procedures. From their answers it appears that family practitioners do not consider their counseling to be the practice of "psychiatry."

Referral Patterns of Family Practitioners: While diagnostic and treatment patterns are important to an understanding of the family practitioner and his practice, his patterns of referral are equally interesting. The physician can refer his patient to another physician, or to a community health agency. This latter type of referral has become one of increasing importance in the new family practice specialty.[11,12]

Practitioners referred from one to four patients a month to specialists. The patients tended to be either medical or surgical and the numbers partially relate to the number of patients seen in these categories. Pediatric patients were referred, on the average, least of all.

Practitioners were asked to choose reasons for referral of patients. "Not enough time" was marked by 18, while 62 marked "special diagnostic skill needed" and 65 marked "special treatment skill needed."

The most frequent patient referrals to agencies by family practitioners are to mental health, to a social worker, to a physical therapist and to Alcoholics Anonymous. Over half of the practitioners indicated they used these community health resources. In decreasing order of referrals were: minister or priest, speech therapist, occupational therapist, maternal and child health, remedial reading, cerebral palsy, legal aid, visiting nurses, and Crippled Children. When practitioners were asked why they might have difficulty in referring patients to community health agencies, they mentioned that they had little familiarity with the community's referral facilities. Others had received poor advice regarding availability of services and had trouble placing patients.

Specialization and Preference Within Family Practice: The respondents were asked to rank their interests in the five practice categories of medicine, surgery, pediatrics, obstetrics-gynecology and psychiatry. The respondents marked medicine as their special interest in 45 percent of the cases (32 physicians). Forty-one percent ranked surgery first. Only 13 percent ranked obstetrics-gynecology at the top, and 7 percent ranked pediatrics first. Psychiatry drew the smallest interest response with six percent.

In another question the respondents were asked to indicate their interest in doing more or less of the five categories mentioned above. For example, "If I had a choice I would prefer to do more (or less) surgery." An "interest in community activities" category was included. Forty-one percent indicated a wish to do less surgery. Forty-two percent of the respondents (31 physicians) preferred to do less psychiatry and only 14 percent would like to do more. Forty-two percent would choose to do more community activities, while 14 percent would like to do less.

In order to determine if there were some patterns in the monthly activities reported by the survey sample, each item was summarized on a three or four point scale from "none" to "low involvement," through "moderate," to "high involvement" in the particular topic. The relationships among these scores with one another were then statistically determined. A correlation coefficient was used. Six major areas of medical activity were thus identified: Area 1, pediatrics; Area 2, obstetrics-gynecology; Area 3, internal medicine; Area 4, surgery; Area 5, counseling; and Area 6, chronic care. The correlation coefficients for one set of major activity, Areas 1, 2 and 4, were highly homogeneous. This type of practitioner tends to concern himself mostly with pediatrics, obstetrics-gynecology and surgery, but in a context of a practice which includes concern for internal medicine and counseling. These practitioners are relatively less involved in the care of chronic diseases. In fact, most will not have even one patient in a nursing home. These practitioners tend to be somewhat younger. The correlations between major activity Areas 3, 5 and 6 indicate the presence of another interest pattern. These practitioners tend to do internal medicine, and see counseling and chronic care patients. These physicians have few distinguishing characteristics, other than their involvement in these areas and the fact that they are somewhat older.

Discussion

This survey comprises one of the few questionnaire investigations of what family practice is really like. In 1956 Peterson, Andrews, Spain and Greenberg documented one of the most complete studies of this type ever done,[13] although other studies have been carried out since that time.[14,15,16] Our study found that family practice is primarily the practice of medicine and pediatrics rather than surgery, obstetrics-gynecology and psychiatry. Almost all family practitioners use some form of diagnostic studies in addition to routine examination procedures. One half the survey sample reported they did some office x-ray work. Other than routine urinalysis, electrocardiograms and complete cell blood counts, little in the form of diagnostic procedures is utilized by the typical practitioner.

Most practitioners perform biopsy, tonsillectomy and adenoidectomy and dilatation and curettage but tend to refer their patients to specialists when a larger procedure is called for. (Family practitioners typically assist in the operations in those cases.) Perhaps, more time spent in the practice of assisting rather than doing these procedures would be of benefit in residency training.

Approximately one-third of all those physicians surveyed do not practice obstetrics. In contrast we found a large involvement by family practitioners in personal counseling of patients. Again, this information might be considered in apportioning training time.

While physicians may be willing to refer acutely ill patients because of a need for a diagnostic or treatment skill, more encouragement might be needed where the issue concerns referral of chronic disease patients for rehabilitation. Reticence occurs, according to one investigator,[11] because of the need to surrender treatment of the patient to a non-physician. Without specific experience to help us learn that teamwork is required, we are likely to retain unaccepting attitudes in our referrals to community health team workers. Wylie[17] found while studying referral practices of physicians in the Baltimore, Maryland, area that 54 percent of a group of general practitioners did not refer even one stroke patient during the period from 1956 to 1964 to an existing inpatient rehabilitation center.

No one believes that all physicians entering family practice are alike, yet there has been little investigation into whether or not all family practitioners tend to be involved in essentially the same types of practice activities. Our study shows two patterns of practice, although there may be many more.[18,19] Since the concept of a family practice is one of inclusion, how do such varied patterns fulfill this criterion? The role of the family practitioner is one of function as well

as of content so that all of these practitioners could serve as the primary physician to the patient. In fact, a special interest in one area of the medical spectrum would tend to give the physician a feeling of grasp in that field. One family practice residency program arranges for fellowships in the last year of training much as is done in other residencies.[11]

We are seeing a period of transition from general practice in all its varied forms, to the new family practice model which is much better defined. The new physician entering practice will have a clearer expectation of the family practice role. In this way he will realize that the special skills of continuing patient care make him a specialist in every way.

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MYOCARDIAL INFARCT AND VPB'S

If a patient with myocardial infarct exhibits multiple ventricular premature beats (VPB's), 10 to 15 per minute, unifocal, but they don't intercept the vulnerable period, would you allow this to continue and not be concerned or would you treat?

The setting has to be defined. If the patient had an acute myocardial infarction a few hours ago, if he has many ventricular ectopic beats, I think he ought to be treated, irrespective of where the beats fall. Because in effect if you have a policy that begins to accept certain ones, you have already opened up a potential Pandora's box. Paramedical personnel are frequently carrying out your instructions. When we compare nurses' monitoring with automatic analog devices or computers, we find that nurses pick up about 30 percent of events. Furthermore nurses miss early and multifocal events; they miss almost all of them. So if you lay down a policy merely based on certain types of VPB's, the nurse busy in a coronary care unit is likely to miss them. In effect it's better to have a policy of treating them all, though it's recognized that many of them are not hazardous.

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